STANDING COMMITTEE ON HEALTH CARE

REPORT RESPECTING THE FINAL REPORT OF THE COMMISSION ON MEDICARE

August 30, 2001

2nd SESSION of the 24th LEGISLATURE

LEGISLATIVE ASSEMBLY OF SASKATCHEWAN

Legislative Assembly of Saskatchewan
Standing Committee on Health Care

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August 30, 2000

To the Honourable Members of the Legislative Assembly

HONOURABLE MEMBERS:

Your Standing Committee on Health Care has the honour to present its report on responses to the Final Report of the Commission on Medicare and commends it to the House.

Judy Junor
Chair
MLA Saskatoon Eastview

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The Standing Committee on Health Care expresses its sincere thanks for the assistance it received from various branches of the legislative service, which contributed in many different ways to the business of the Committee.

The Committee extends its appreciation to Mr. Viktor Kaczkowski who served as the Clerk to the Committee. Members of the Committee are grateful for the expertise and diligence of its Research Officer, Ms. Leslie Anderson in the preparation of this report. The Committee also acknowledges Ms. Zorka Ripplinger and the other staff of the Office of the Clerk, who assisted in the logistical organization of the public hearing schedule and meetings. Special thanks are also extended to Mss. Donelda Klein, Lynette Nicholas, Darlene Trenholm, and Kathy Wells of the *Hansard* Branch; as well as Mssrs. Gary Ward, Kerry Bond and Ihor Sywanyk of Legislative Broadcast Services, for their assistance during the public hearing process. The Committee also thanks the other staff members of the Legislature who supported the work of the Committee.

The Committee also wishes to extend its appreciation to all the individuals and groups who made oral presentations and submitted written briefs. The information presented and the opinions expressed were of valuable assistance in reviewing the recommendations contained in the Final Report of the Commission on Medicare.

COMPOSITION OF THE COMMITTEE

Chair:	Ms. Judy Junor	MLA Saskatoon Eastview
Vice-Chair:	Hon. Jim Melenchuk	MLA Saskatoon Northwest
Other members:	Ms. Brenda Bakken	MLA Weyburn-Big Muddy
	Hon. Buckley Belanger	MLA Athabaska
	Mr. Bill Boyd	MLA Kindersley
	Mr. Rod Gantefoer	MLA Melfort-Tisdale
	Mr. Warren McCall	MLA Regina Elphinstone
	Mr. Andrew Thomson	MLA Regina South

Membership adopted May 23, 2001

Members substituting for permanent members of the Committee on an occasional basis:

Ms. June Draude, MLA Kelvington-Wadena
Hon. Keith Goulet, MLA Cumberland
Hon. Doreen Hamilton, MLA Regina Wascana Plains
Ms. Donna Harpauer, MLA Watrous
Mr. Glen Hart, MLA Last Mountain-Touchwood
Ms. Debbie Higgins, MLA Moose Jaw Wakamow
Hon. Pat Lorjé, MLA, Saskatoon Southeast
Mr. Mark Wartman, MLA Regina Qu'Appelle Valley
Mr. Kevin Yates, MLA Regina Dewdney

STAFF

Mr. Viktor Kaczkowski, Clerk Assistant (Committees)
Ms. Leslie Anderson, Research Officer
Ms. Zorka Ripplinger, Office Assistant

TERMS OF REFERENCE

On May 16, 2001, on motion of the Hon. John Nilson, seconded by the Hon. Jim Melenchuk, the Legislative Assembly created a new permanent committee of the legislature, the Standing Committee on Health Care. This Committee, as with the other standing committees, is empowered to examine and inquire into all such matters and things as may be referred to it by the Assembly, and to report from time to time its observations. Accordingly, the committee also has the authority to send for persons, papers and records, and to examine witnesses under oath.

A subsequent order of the House, dated May 23, 2001, established that membership on the Committee was to consist of four Government members, three Official Opposition members, and one coalition Liberal member (the members being those noted previously) and that, pursuant to Rule 94(4), the membership may be transferable by written notice, thus allowing for the temporary substitution of one member for another.

On May 25, 2001, the Standing Committee on Health Care received its first Order of Reference, which reads as follows:

> *That the Standing Committee on Health Care be instructed to receive and report on representations from interested parties and individuals with respect to the Final Report of the Commission on Medicare, dated April 11, 2001;*
>
> *And that the Standing Committee have the authority to sit during the intersessional period and during the legislative session except when the Assembly is sitting; to engage such advisors and assistants as are required for the purposes of the hearings;*
>
> *And that the Standing Committee be authorized to televise the proceedings on the Saskatchewan Legislative Network;*
>
> *And that the Standing Committee be authorized during any period of adjournment to make a report on its inquiries by filing the same with the Clerk of the Legislative Assembly; and that the report shall be distributed in accordance with The Tabling of Documents Act;*
>
> *And that the Standing Committee file a written report no later than August 30, 2001.*

ORGANIZATION

On June 4, 2001, the Committee held its first meeting and elected Ms. Judy Junor as Chair, and the Hon. Jim Melenchuk as Vice-Chair. A Sub-committee on Agenda and Procedure (Steering Committee) was appointed, consisting of the Chair and Vice-Chair and Mr. Rod Gantefoer, MLA. At this time, the Committee agreed to recommend to the Legislative Assembly that the Committee be authorized to use the Legislative Chamber to facilitate the televising and internet-streaming of its public hearings; this recommendation being adopted by the Assembly on June 5, 2001. The committee also agreed to seek research assistance and, upon the recommendation of its Steering Committee, selected Ms. Leslie Anderson for the position of Research Officer for the duration of the committee's consideration of this matter.

METHOD OF OPERATION

Soon after the Committee was established, the Steering Committee met to consider how it should proceed with its consideration of its Order of Reference. At its meeting of June 11, 2001, the committee adopted the Steering Committee's proposed recommendations with minor amendments, the implementation of which is summarized below.

Recognizing the need to canvass a wide variety of opinion, members of the public were invited to make their views to the Committee known, either orally, in writing or both. To this end, the Committee agreed that advertisements giving notice of the Committee's proceedings were to be placed in all of the daily and weekly newspapers in Saskatchewan. In addition, the advertisement was placed on the Saskatchewan Parliamentary Channel and on the Legislative Assembly's website, and to reach northern residents, radio announcements were also placed. Notices of the hearings were also mailed or faxed to numerous stakeholders.

The committee held its hearings on June 26, 27, July 3, 4, 10, 11, 17, 18, 24, 25, and 26 in the Chamber of the Legislative Building. A complete list of the witnesses appearing on each of these days is provided in Appendix I and Appendix II contains a list of all the written documents received by the Committee. Throughout the public hearing process, the Committee stressed that the Committee's mandate was *"to receive and report on representations from interested parties and individuals with respect to the Final Report of the Commission on Medicare"* and that it was not within its purview to propose specific recommendations with regard to the direction of a health care strategy for the province.

Over the course of almost 60 hours of sitting time, a total of 109 individuals and organizations appeared before the Committee from which the Committee received 134 written briefs. The Committee received an additional 512 written submissions, and, although the deadline for their receipt was set as July 27, 2001, the Committee has since received another twenty.

Executive Summary

Reaction to the Fyke Commission on Medicare ranged from extremely supportive to extremely critical to somewhere in between, depending upon the particular recommendation being discussed. The Standing Committee on Health Care heard testimony and received submissions from a wide range of groups and individuals who possessed differing degrees of knowledge of and experience with the health care system. A lack of shared understanding of the terms and concepts used in the report appeared to exist among members of the public and health care providers and as a result, at times, the recommendations in the report meant different things to different people.

Responses to Chapter One: Everyday Services

Generally speaking, the majority of health care provider groups reacted positively to the recommendations put forward by the Commission on Medicare. The level of support, however, can be described as ranging from extremely enthusiastic to somewhat guarded. For example, on the one hand the Saskatchewan Association of Licensed Practical Nurses maintained that, "The report builds on our strengths and provides us with a blueprint for enhancing and sustaining medicare for the people of our province. It is comprehensive, integrated and reflects quality over quantity, collaboration and cooperation – all attributes that reflect our history and tradition in this province. Our Association urges the government and opposition parties to join forces now to collaboratively facilitate the Fyke report recommendations." On the other hand, the Committee also heard less enthusiastic reactions, such as that from the Saskatchewan Medical Association who stated that, "The Fyke report, while dealing adequately with some issues, fell significantly below our overall expectations."

Support for the concept of a primary health care service model was expressed by the vast majority of respondents. Support was also strong for the recommendation to create primary health services teams. The Committee also heard repeatedly, however, that the proposed alternate model of health service delivery must be in place and proven effective prior to any restructuring of current health care services or to the closure/conversion of rural hospitals.

Reponses to Chapter Two: Specialized Care

While acknowledging that the Fyke report contained some positive recommendations, the written and oral submissions received from towns, rural municipalities and individual residents of rural Saskatchewan focused almost exclusively on the perceived negative impact of the closure or conversion of smaller rural hospitals. Most health districts also felt Fyke's recommendations were too extreme and that the proposed consolidation of rural hospitals was too drastic. In this regard the Committee heard that a number of hospitals somewhere in between 70 and 20 may be more appropriate and acceptable to residents of rural Saskatchewan. Health care provider groups were divided on Fyke's recommendations to close or convert rural hospitals.

With respect to the Commission's recommendations regarding emergency response and medical transportation, rural residents were almost unanimously of the view that the standard distances set for travel to emergency services were unacceptably long, and that Fyke's recommendation to establish a centralized, province-wide emergency dispatch would result in even longer response times. All of the written and oral submissions that addressed the issue of ambulance fees, however, supported Fyke's recommendation that fees should not be based upon distance and that they should be standardized for rural and urban residents.

Responses to Chapter Three: Making Things Fair

Generally speaking, support was expressed for the Commission's recommendations regarding health promotion, disease and injury prevention and developing strategies to address the broader determinants of health, although some respondents felt the Commission did not go far enough in addressing these issues.

Very few respondents spoke directly to the issues surrounding northern health care but those who did clearly supported Fyke's recommendation for the continuing development of a Northern Health Strategy.

Reponses to Chapter Four: Getting Results

The recommendation to establish a Quality Council was received positively by most respondents but the Committee also heard that the powers and membership of the proposed Council require further clarification.

Responses to Chapter Five: In Support of Change

Over the course of the public hearings, and in the written submissions received by the Committee, no consensus emerged with respect to the Commission's recommendation for health district consolidation. Reaction ranged from very positive, to very negative, to neutral on Fyke's health district models.

If a lack of consensus emerged with respect to the appropriate number and size of health districts, even less consensus was evident regarding the composition of health district boards. Some respondents felt all board members should be elected, others felt all should be appointed and still others favoured the current blended system of elected and appointed members. Similarly, opinion was divided on whether individuals who have a salaried or contractual relationship with a health district should be eligible to seek election or be appointed to a health district board.

Fyke's recommendation to clarify the relationship between health districts and the Government of Saskatchewan was met with universal approval.

As with the Northern Health Strategy, very few respondents spoke directly to the issue of health care service delivery for Aboriginal people, but those who did expressed support for Fyke's

recommendation for a structured dialogue, and agreed that Aboriginal health care must become a higher priority on the health care agenda.

With respect to human resources, health care provider groups generally expressed support for the Commission's recommendation to coordinate human resources planning and management on a provincial basis. Respondents tended to focus their comments on current health care staff shortages and the need to address issues of recruitment and retention.

The University of Saskatchewan, health care provider groups and others who addressed the issue approved of Fyke's recommendation to increase the amount of funding devoted to health research. The Committee also heard strong support expressed for the report's recommendations regarding investments in information systems, including the development of an electronic health record.

Responses to Chapter Six: Paying the Bills

On the issue of "paying the bills", the Committee heard repeatedly that the 40 per cent share of the provincial budget currently being allocated to health care should be sufficient, and, that our health care system should continue to be administered and funded publicly through general taxation.

Many respondents expressed strong opposition to user fees in any form. The Committee also heard, however, that some individuals and communities would be prepared to accept some form of user fee rather than lose their local health care services or facilities.

In addition, several groups suggested to the Committee that health care coverage be expanded to include additional services and/or medications and supplies not currently funded under medicare.

Differing views were presented to the Committee with respect to how physicians in Saskatchewan should be remunerated. No clear consensus emerged on this issue.

In addition, several groups and individuals drew to the Committee's attention a variety of issues and areas they felt had been missed or insufficiently dealt with in the Commission's report. These are outlined in the final section of this document under the heading, "Other Concerns".

In conclusion, the response to the Fyke Commission on Medicare can best be described as "mixed" - ranging from extremely positive to extremely negative depending upon the particular recommendation being discussed.

Note:
In their responses to the Commission on Medicare, most witnesses linked the recommendations regarding small hospital conversion (Chapter One) with the recommendation to establish 10 to 14 Regional Hospitals (Chapter Two). For this reason, in this document the responses to the recommendations regarding small hospital closure/conversion (Chapter One) have been included with the responses to the recommendation to establish regional hospitals (Chapter Two).

Responses to Chapter One: Everyday Services

To address everyday health needs, the Commission on Medicare recommended the development of an integrated system for the delivery of primary health services by:

- **Establishing Primary Health Service Teams bringing together a range of health care providers including family physicians;**
- **Integrating individual teams into a Primary Health Network, managed and funded by health districts, which includes enhanced community and emergency services.**

Primary Health Services

Support for the concept of a primary health services model was expressed by the vast majority of witnesses who appeared before the Committee. Several respondents, including the Saskatchewan Association of Health Organizations noted, however, that the provision of primary health care services should be viewed as a stand-alone issue, and "should not be tied to the loss of diagnostic, acute and emergency services in local communities." Or as the North East Health District put it, "Decisions about acute care facilities should be kept separate and apart from the development of primary health care initiatives."

The Committee also heard repeatedly that the proposed primary health care service model must be put in place and proven effective prior to any restructuring of the existing services or to any closure or conversion of rural hospitals. As well, it was suggested by several respondents that the primary health care model is needed in urban as well as rural and Northern areas of Saskatchewan.

Many respondents expressed concern about the Commission's vagueness and lack of detail regarding how primary health care services would be delivered. The Twin Rivers Health District maintained, "The Commission states that a team-based delivery of primary health services is recognized around the world as the most effective way to deliver health services. However, the report does not identify how the system would be delivered in rural areas." The Prairie West Health District stated, "The Report fails to explain what is meant by primary health services." And the Saskatchewan Medical Association, while supporting the need to develop a comprehensive strategy for primary health care delivery, told the Committee they are "concerned about the desire of public policy makers to reform the primary health care system without a clear vision or objectives, a lack of cost effectiveness data, and analysis of alternate primary delivery models."

The Committee also heard that citizen participation and extensive consultation with communities should occur before final decisions are made regarding primary health care service delivery.

Primary Health Service Teams

Support was also strong for the recommendation to establish Primary Health Service Teams. It should be noted, however, that many communities expressed the view that their health care providers are already working as members of an effective and efficient "team". The Saskatchewan Medical Association maintained that, "Contrary to suggestions in the Fyke report, physicians do recognize the importance of, and actively participate in, a team approach to patient-centred care." On the other hand, the Committee also heard from the College of Physicians and Surgeons that, "Short of the few pilot projects that have been underway, teamwork really isn't happening right now, and we need to find ways to connect people to work more effectively as a team."

Several groups of health care providers maintained that their members should be included in some form as members of the Primary Health Services Team. These included the Registered Psychiatric Nurses Association, the Canadian Mental Health Association (Saskatchewan Division), the Medical Laboratory Technologists, the Midwives Association of Saskatchewan, the Chiropractors Association of Saskatchewan, Medical Herbalists, Complementary Therapists, the Canadian Diabetes Association (Saskatchewan Division), the Catholic Health Association of Saskatchewan/Saskatchewan Catholic Health Corporation, the Saskatchewan Society of Occupational Therapists, the Saskatchewan Palliative Care Association, Dieticians of Canada (Saskatchewan Region), the Saskatchewan Physiotherapy Association, the Saskatchewan Psychological Association, the Representative Board of Saskatchewan Pharmacists, the Saskatchewan Pharmaceutical Association, the Saskatchewan Union of Nurses, the Saskatchewan Association of Licensed Practical Nurses, and the Saskatchewan Registered Nurses Association.

Many respondents also suggested that in the future, solo practitioner medical practices would likely be replaced by a "team" approach. For example, the Saskatchewan Association of Rural Municipalities told the Committee that, "One thing we have to look at is the single practitioner concept – the backup, the rationale, the quality of life for the solo practitioner. It's fair to suggest that in the near future we will not see that as common practice. With the team concept, where you have five or six physicians, physicians can take some time off, have backup and colleagues they can confer with…We would suggest that the hospital of the future in Saskatchewan is going to have a least two and preferably five or six physicians on a team."

Reponses to Chapter Two:
Specialized Care

To ensure high quality diagnosis and treatment, the Commission on Medicare recommended the development of a province-wide plan for the location and delivery of specialized services that would include:

- **Tertiary services delivered in Saskatoon, Regina and Prince Albert;**
- **A network of 10 to 14 Regional Hospitals to provide basic acute care and emergency services;**
- **Converting many small existing hospitals into Primary Health Centres, designed to support Primary Health Teams (recommendation from Chapter One);**
- **Ensuring that comprehensive services are available 24 hours a day, seven days a week, including a telephone advice service (recommendation from Chapter One);**
- **Districts contracting with specialists; and,**
- **Utilization of beds and resources based on standards established by a Quality Council.**

Tertiary Hospitals

The vast majority of submissions remained largely silent on Fyke's recommendations regarding tertiary hospitals. However, the Committee heard from the Regina Health District that, "The report designates Regina, Saskatoon and Prince Albert as tertiary centres. Considering the relatively small population of Saskatchewan, at one million people, it is recommended that the inclusion of Prince Albert as a tertiary centre be reviewed in detail before such a designation is confirmed. The ability to maintain more than two centres may cause confusion over the capability of the health services in Prince Albert, and may not be as cost effective as a two site tertiary care model." The Saskatchewan Psychological Association also observed that, "The Fyke report recommends three centres for tertiary care...adjacent provinces with larger populations have fewer tertiary centres, which begs the question of whether this report goes far enough in recommending sufficient change to alleviate fiscal crisis."

In their written submission to the Committee, the North Valley Health District recommended that a tertiary centre be located in Swift Current in addition to Regina and Saskatoon.

Regional Hospitals

The Committee heard support for the report's recommendation to establish regional hospitals from communities and health districts who felt their particular hospital would or should be chosen as one of Fyke's proposed 10 to 14 regional hospitals. These included the City of Swift Current, the Lloydminster District Health Board, the Town of Kindersley, the Battlefords District Health Board and the City of Humboldt.

As the Mayor of the City of Humboldt put it, "We fully expect St. Elizabeth [Humboldt] to be a regional hospital as we currently offer, if not all, most of the services proposed for a regional hospital in Mr. Fyke's report."

Or as the City of Swift Current maintained, "For our health care system to be successful, there must be change. The viability of providing the type of service and support that ensures excellence in health care in every currently existing facility is non-existent. The costs of staying technologically current are exorbitant and recruiting top quality medical professionals at best requires a willingness to commit to a strategy of support, both in terms of offering opportunities for growth and a challenging environment, as well as a commitment to keeping pace with rapidly advancing technology in a variety of diagnostic treatment areas. Such a commitment can only succeed on a regional level where there exists an opportunity to adopt a more focused approach to meeting the resource needs of such development."

"It is difficult to believe that once a true understanding of what establishing regional centres of excellence could mean to patient outcomes, people would be willing to forego that potential to accept the lower quality of health services that would inevitably result from trying to operate more facilities than we could possibly afford."

Hospital Conversion/Closure

With respect to the Commission on Medicare's recommendations in Chapter Two, the oral testimony provided by representatives of towns and rural municipalities, as well as the written submissions received from hundreds of rural Saskatchewan residents, focused primarily – and at times, exclusively – on the perceived negative impact of the closure or conversion of rural hospitals.

While acknowledging that there are many positive recommendations contained in the Commission on Medicare's report, the overwhelming majority of towns, rural municipalities, and individual rural citizens were of the view that if Fyke's recommendations regarding rural hospital closure/conversion were implemented, the following consequences would result:

- More demand would be placed on larger tertiary and regional hospitals, thereby exacerbating overcrowding and contributing to even longer waiting lists.
- Unacceptably long travel times would be required for rural residents to reach regional hospitals. Longer distances would also result in increased travel, accommodation and meal costs for rural citizens. Inclement weather and poor highway conditions could make travel times even longer.

- In contrast to the province's current objective to achieve rural "revitalization", the recommendations would result in rural "devitalization", that is, businesses would relocate to other provinces, jobs would be lost and a negative economic domino effect would be felt in rural Saskatchewan.
- Seniors would relocate and retire to larger communities in order to be closer to acute health care services.
- Rural hospital beds would not be available to accommodate convalescing patients after they receive surgeries in larger hospitals. As a result, beds in larger hospitals would be tied up needlessly and patients would not have the advantage of recovering in familiar surroundings and close to family and friends. In addition, palliative and rehabilitative services would not be available close to home.
- The loss of diagnostic and laboratory services and reduced access to acute care beds would make it even more difficult to recruit and retain rural physicians.
- Significant cost savings would not be achieved.
- Distances to emergency room services would be too great and would jeopardize the first critical or "golden" hour of care.

The Saskatchewan Association of Rural Municipalities summarized the response of the province's rural municipalities as follows: "While some changes to the current health care system may be necessary, they should not be at the expense of rural Saskatchewan as is the case with the recommendations outlined in the Fyke report. If the Fyke report were implemented, a 'two-tiered' health care system would be entrenched: one system for large urban centres and one for the remainder of the province. Every citizen in the province deserves equal access to health care, regardless of where they live."

The majority of health districts that appeared before the Committee shared these concerns. Typical of the response of health districts was the testimony of the Pasquia Health District representatives who said, "The Pasquia Health District supports many of the recommendations included in Fyke's report...the Pasquia Board is open to continued change, but the recommendations in the Fyke report are seen as too extreme. They will result in bringing about the demise of rural Saskatchewan and will undoubtedly have a negative effect on the overall viability of the province of Saskatchewan."

Similarly, the Prairie West Health District spoke of their "extreme objections to the discrimination towards rural residents by the Fyke report." And the Gabriel Springs Health District maintained that, "The Fyke recommendations, taken in their purest form, would exact a huge cost on rural Saskatchewan and would result in an inequitable health care system in the province."

Some health care provider groups either implicitly, through their blanket approval of all of Fyke's recommendations, or explicitly, by specifically articulating their approval of Fyke's proposals in Chapter Two, supported the recommendations for hospital conversion or closure. For example, representative of the Saskatchewan Association of Licensed Practical Nurses maintained that, "Often we mistake convenient care for quality care. Fyke's recommendations to beef up our regional hospitals would be a real bonus for proper utilization of services."

Other health care provider groups, however, were critical of the recommendations, including the Saskatchewan Union of Nurses who said, "Primary health reform must not be a smokescreen for cutting existing acute, long-term care or rehabilitative services...Existing acute, emergency, long-term care and rehabilitative services must be enhanced, not downgraded...rural Saskatchewan citizens must not face and will not tolerate another round of rural hospital or integrated facility closures or conversions under the guise of 'health reform.'"

Similarly, the Saskatchewan Medical Association maintained that, "Mr. Fyke leaves the impression that small rural hospitals are not really providing 'acute care'. While that may be true in some areas, it is certainly not true generally. He clearly underestimates and diminishes the scope of acute care currently provided in many small urban and rural hospitals...acute care is currently being offered with consistent high quality in many communities targeted for conversion/reconfiguration."

In their written submission, the Society of Rural Physicians of Canada (Centre Region) made the observation that, "If adequately staffed and equipped, smaller hospitals can generate better outcomes," and that, "It is unlikely that further wholesale hospital closures will save any more money."

The Saskatchewan College of Family Physicians concurred, and in their submission to the Committee stated, "We cannot support the massive closure of rural hospitals called for in the report. Before hospital closure takes place, the Government should take a hard look at each individual hospital, assess what services the hospital offers and what alternatives are available. Many hospitals are doing a good job and any type of conversion must be done on an individual basis."

Alternatives Must Be In Place

The Committee heard from a variety of witnesses that the proposed primary health care delivery system must be in place and proven effective before any changes are made to the current system of health care delivery. For example, according to the North East Health District, "Primary health care services have to be in place prior to changes in small rural hospitals." Or as the Wolseley Health Committee put it, "Do not change anything until the replacement system is in place!" And the Prairie West Health District advised, "Don't make any changes without knowing that the alternative you are proposing is in place and working."

Something In Between

The Committee heard on numerous occasions that something in between the current 70 and Fyke's recommended 20 hospitals may be needed. As stated by the College of Physicians and Surgeons, "A sudden consolidation from 70 to 20 hospitals is a more drastic change than would likely be tolerable."

Many of the delegations who appeared before the Committee suggested that, "The gap in services provided by regional hospitals and community care centres, as proposed by Fyke, is much too large" (Town of Esterhazy) and that, "There is room in the system for smaller regional

hospitals where reasonable pools of physicians can be maintained and a wide range of services can be offered." (Town of Moosomin)

Dr. Jaco Greyling, who appeared before the Committee as a member of the Redvers delegation, agreed with this observation and told the Committee that, "Another level of service is needed in between the community care centre and the regional hospital. We need a level of hospital that would still have acute care beds..."

The Committee also heard that regional services are already being delivered in many areas of the province under the current health care model. For example, representatives of the Town of Tisdale told the Committee that, "The northeast has already taken a regional approach to health care with Tisdale servicing a large area to the south and east and working collaboratively with Nipawin and Melfort. Melfort provides a surgeon who travels to both Tisdale and Hudson Bay. Tisdale and Melfort share a joint contract for a radiologist to serve both communities. A medical officer of health has been jointly funded by all three health districts with Saskatchewan Health. And the dialysis treatment facility is Tisdale's contribution to servicing the whole of the northeast."

Similarly, the Turtleford Health Advisory Committee stated, "Our team extends past our health district boundaries into the neighbouring community of Edam. Physicians from Turtleford and Edam share a scheduled on-call rotation. This has fostered and enhanced programs, and has brought about plans for further training of professional staff, particularly Advanced Clinical Life Support for the physicians and our registered nurses."

Some witnesses suggested that a "pilot project" approach to the changes proposed by Fyke may be useful. For example, the Saskatchewan Registered Nurses Association recommended that in order to help alleviate concerns about the effects of health care reform, "Saskatchewan should become a global Centre of Excellence for primary health care by establishing two primary health care demonstration projects, one in rural Saskatchewan and one in urban Saskatchewan, by the Spring of 2002." Similarly, witness Dean Smith of Swift Current proposed that, "In order to stimulate public involvement in health care reform, I believe we need to create a pilot project on health care reform so that people can give feedback on a pragmatic health care model. I would even go further by suggesting we set up such a project in the Southwest, which was the home of medicare."

The Central Plains Health District suggested that, "A reduction of this magnitude is a monumental change which may shake the confidence of rural residents for years to come. We propose that a reasonable alternative may be to target specific community care centres to provide basic primary acute care. These limited numbers of community care centres would be strategically located and aligned with regional hospitals. We would propose that these targeted community care centres be located in geographic areas where travel times [to regional hospitals] are at the uppermost limits."

Economic Impact

The possible economic impact of Fyke's proposals, and the question of whether health care and economic development issues should be linked were also raised on several occasions. Some respondents argued that supporting community economic development is an important aspect of rural health care. For example, the Mayor of Tisdale told the Standing Committee that, "The major drawback of the Commission on Medicare is that its attempts to cut health care costs would be detrimental to the goals of expanding our economy." The Town of Moosomin went as far as to say that, "Approximately 40 per cent of the provincial health budget should be considered economic development."

The Standing Committee also heard arguments to the contrary, such as the following from the representatives of the City of Swift Current who stated that, "Health care should not be a political or economic development issue. It concerns only the health and well being of our residents and providing them with the best possible diagnostic and treatment services available." Similarly, the College of Physicians and Surgeons asked, "Do you use the health system resources for economic development or sustenance? If you want to sustain rural communities, you can do it through a variety of budgets and vehicles. But at least be honest about what you're doing. It's not delivering logical health services – it's trying to prop up an economic structure under strain."

Emergency Response and Medical Transportation

With respect to the Commission's recommendations regarding emergency response and medical transportation, the feelings of rural respondents are reflected in the following statement offered by the Pasquia Health District: "We believe the standards set for the distance to emergency room services are too great to provide safe emergency services. The report sets out a standard of a maximum of 60 minutes travel time to a hospital for 88 per cent of the population and a maximum of 80 minutes travel time for 98 per cent of the population. The distances proposed would be too great for many emergency situations that can and do arise in rural areas...we believe the standard of 30 to 45 minutes, as is presently set for physicians to respond to emergencies, is more realistic. Rural residents should not be expected to accept less."

Rural respondents also feared that the Commission's recommendation to establish a centralized, province-wide emergency dispatch would result in longer response times - which would be made even worse in the event of unfavourable road and weather conditions.

The Saskatchewan Emergency Medical Services Association told the Committee that they support the existing emergency dispatch system and that, "More resources may be required to improve the consistency of our system, but basically it's working well. Our system is not broken and we don't need to fix it."

With respect to staffing, the Saskatchewan Emergency Medical Services Association also stated that their short term goal is to have one EMT-basic on every call and that over the next four years, they want to see the minimum standard increased to one EMT-advanced on every call. The Saskatchewan Association of Rural Municipalities observed that, "The report recommends a

minimum standard of one basic emergency medical technician and one emergency medical responder for each ambulance. This may not be practical unless these individuals can be deployed in nursing homes, community care centres, hospitals or community programs because in smaller centres individuals spend a very small proportion of their duty hours responding to calls." The Saskatchewan Government Employees Union said that they "support the report's suggestion that would allow EMS workers to work in long term facilities and recommend that people employed in long term facilities be trained to work in Emergency Medical Systems as well." And the Redvers Health Centre Emergency Medical System representatives told the Committee that, "The only hurdle to establishing basic EMT and EMR as the minimum ambulance crew staffing level is the matching of personal and work schedules. The solution to this recommendation would be the expansion of duties within our health centre as three of our volunteer ambulance personnel already have positions within our health facility."

All of the written and oral submissions that addressed the issue of ambulance fees supported Fyke's recommendation that fees should not be based upon distance and that they should be standardized for rural and urban residents. In addition, the Canadian Union of Public Employees stated their preference for "an all public, provincial emergency services system."

24-Hour Telephone Advice

A very small number of witnesses directly addressed Fyke's recommendation to establish a provincial call centre to provide 24-hour telephone advice. Of those who did, many were of the view that the telephone triage system proposed by Fyke is already up and running in rural Saskatchewan. The Turtleford Health Advisory Committee told the Committee that their "nurses, physicians and pharmacists already provide a telephone advice service quite adequately." And according to the Society of Rural Physicians (Central Canada), "Statistics are provided in the report to demonstrate the effectiveness of a telephone triage system. What the report fails to note is that telephone triage is already being provided free by rural hospitals. Most patients who are unsure of their needs do call their local hospital for advice and get the benefits of a nurse's opinion and that of a physician if the nurse feels it is appropriate."

The Regina Health District supported the concept of a 24-hour health advice telephone service but added that, "With the organization of tertiary services being in Regina and Saskatoon, we believe that two telephone advice services are required, one in Regina and one in Saskatoon."

Responses to Chapter Three: Making Things Fair

To maximize the health of the people of Saskatchewan, the Commission on Medicare recommended the continuation and/or development of:

- **Public health, health promotion and disease and injury prevention strategies;**
- **Regular reports on defined and measurable goals;**
- **Strategies to address the broader determinants of health; and**
- **A Northern Health Strategy.**

Health Promotion, Disease and Injury Prevention and the Broader Determinants of Health

Generally speaking, support was expressed for the Commission's recommendations regarding health promotion, disease and injury prevention, and strategies to address the broader determinants of health. Most respondents agreed that a good system of prevention is the best way to reduce the cost of medicare while improving the health of Saskatchewan citizens over the long term, and, that there is both a societal and individual responsibility for promoting health and preventing disease and injury.

For example, according to the Saskatchewan Union of Nurses, "Reform of primary health services and a shift from 'sickness care' to health prevention and promotion promises enormous economic savings, along with relieving Saskatchewan citizens of the terrible human cost of preventable, long term illness and premature death. But these will be long term savings, and primary care reform will require funding over and above existing services."

The Saskatchewan Registered Nurses Association also said they "support comprehensive primary health care which focuses on preventing illness and promoting health by examining those factors which influence health, the determinants of health." And the Community Health Cooperative Federation of Saskatchewan said they "strongly agree with Fyke's observations and recommendations concerning the need to focus more of our resources on health promotion, disease prevention, and addressing the determinants of health...Fyke's approach to health care will involve more expenditures in the short term but will be made up by increased savings over the long term."

Some respondents, however, felt that Fyke's recommendations did not go far enough in addressing these issues. For example, the Canadian Union of Public Employees suggested that, "Although Fyke supports social programs that help keep people healthy, his report is fairly general. Canadian Union of Public Employees would like to see more specific strategies outlined

in the report and urges the government to develop strategies to improve the economic and social well being of Saskatchewan residents, especially the most vulnerable." Or, as the Saskatchewan Population Health and Evaluation Research Unit put it, "The task is to make clear to the public that the most important health reform decisions we need to make now are to ensure that our health care system does not unnecessarily drain resources away from those areas that we know are more essential to personal and community health, such as education, housing, employment, a healthy ecosystem, etc. And that our health care system is better equipped to support work across sectors and communities to ensure all people have fair access to these fundamental health determinants. This requires a more detailed population health strategy than was offered in the report."

Similarly, the Saskatchewan Psychological Association maintained that while the Fyke Commission "acknowledges these issues to some extent, the report fails to emphasize this domain to the degree it warrants. Lifestyle is a major determinant of health. With the proposed reforms, how will behaviour be changed at a population level? How will an altered system offer incentives for such desired behaviour change?"

And according to the New Green Alliance, "A good system of prevention is the only way to reduce the cost of medicare while improving the health of Canadians. There is an enormous body of evidence available that demonstrates that poverty, inequality, status, employment and work environment are the key factors in determining good health. The report of the Fyke Commission mentions this briefly (in Chapter 3) but offers no strategy for dealing with the core problem. To the New Green Alliance, this must be the central focus of any health policy based on wellness."

In their written submission to the Committee, the Back to the Farm Research Foundation maintained that, "If any medicare program is going to survive and succeed, it must be built on a foundation of supplying all citizens with pure unpolluted water, an adequate supply of certified organic food, clean air and a clean environment. Otherwise, it is doomed to failure…our concern is about what isn't in the [report's] recommendations about nutrition, environment, health and agriculture."

The Saskatchewan Association of Health Organizations proposed that a "determinants of health" pilot project be established. "Much more needs to be done to improve and promote the health of individuals, families and communities," the Saskatchewan Association of Health Organizations told the Committee. "A demonstrated project advancing a total 'determinants of health' approach to programming could be initiated in one or more areas. This would allow the effects of this comprehensive approach to programming on population health to be evaluated over the long term. This project should include groups such as local economic development authorities, health, education, justice social services and municipalities."

The Prairie Women's Health Centre of Excellence, stated that, "Fyke contains some praiseworthy recommendations" but that the report "fails to focus on preventive care and a more holistic approach to health care." The Women's Health Centre further suggested that an analysis of the report through a "gender lens" was necessary "because health care is used differently by men and women, because the roles of men and women in society affect their relationship and use of health care on behalf of their families, because women are more likely (because of income

status) to be more vulnerable to increases in health costs, and because 80% of the health care workers and providers are women."

With respect to funding promotion and prevention initiatives, the Regina Health District suggested that, "The competition for operating funds makes it very difficult for health districts to prioritize expenditures for long term strategies including health promotion and disease and injury prevention – in other words, the pressure for immediate services takes priority. For this reason, the Regina Health District recommends that Saskatchewan Health allocate a specific percentage of the health budget for health promotion and disease and injury prevention, and that these funds be granted to health districts as designated funds, with specific limitations on their expenditure."

The Saskatchewan Parks and Recreation Association, the In Motion Partnership and the Pro Fit Athletic Club all stressed the importance of physically active lifestyles in achieving and maintaining good health. The Saskatchewan Parks and Recreation Association said they, "strongly believe that a coordinated province-wide program that promotes increased physical activity and extols the virtues of more active lifestyles can play an integral role in addressing some of the issues outlined in Chapter 3 (Making Things Fair) and Chapter 6 (Paying the Bills)." And the Pro Fit Athletic Club suggested that, "government provide additional incentives for companies of all sizes to provide additional fitness benefits to employees."

Northern Health Strategy

Although very few respondents spoke to the issue of the development of a Northern Health Strategy, those who did strongly endorsed supported Fyke's recommendation.

The Committee received its most extensive testimony on this issue from the "Northern Health Stakeholders" a group representing the Athabasca Health Authority, the Mamawetan Churchill River, the Keewatin Yatthe Health District and the Northern Intertribal Health Authority. The Northern Health Stakeholders told the Committee that, "there is a better way to deliver health services in the north...we have some very different, unique, challenging health issues. We believe in holistic and community-oriented health delivery services. We have formed partnerships to address the broader determinants of health."

"Our goal is to improve the health status of northern Saskatchewan residents. We are working from the basic assumption that health is the result of individuals, families and communities learning and applying the natural laws and principles of healthy living in their lives. We believe this is in keeping with the health reform principles as expressed by the Saskatchewan government in increasing community involvement, emphasizing prevention, healthy lifestyles and population health, improving balance, coordinating and integrating client-centred systems, maintaining appropriate services and financial sustainability."

"The Fyke report endorses the Northern Health Strategy...We believe Fyke recognizes the extraordinary circumstances of the north. We believe that the province must now indicate their position regarding the north's initiative and Fyke's endorsement of our strategy. We believe this is an opportunity to build on our work with all our northern partners and support from government."

Responses to Chapter Four: Getting Results

To sustain a quality health system, the Commission on Medicare recommended:

- **Continuing development of performance indicators;**
- **The establishment of a Quality Council;**
- **Annual reports on the health system; and**
- **Incentives and funding to develop accountability and quality.**

With respect to Chapter Four, respondents focused their remarks primarily on the establishment of a Quality Council and remained largely silent on the other three recommendations. Those who did specifically refer to the remaining recommendations (the development of performance indicators, annual reports and incentives to develop accountability and quality) were in most instances supportive.

Quality Council

The recommendation to establish a Quality Council was well received by the clear majority of witnesses who appeared before the Committee. But while the concept of a Quality Council was viewed positively by most respondents, the Committee also heard that the membership and powers of the proposed Quality Council require further clarification.

For example, the Registered Psychiatric Nurses Association said that, "Membership on the Quality Council needs to be more clearly defined. Members should have proven knowledge and expertise and membership should not be limited to regulatory bodies who will bring vested interests to the table."

The Saskatchewan Government Employees Union also pointed out that, "Clarification is required regarding who makes appointments to the Quality Council and on what basis. There needs to be some minimum qualifications required for appointment to the Quality Council and the assurance that the individuals chosen have a good grasp of the practical application of quality health care."

The Saskatchewan Registered Nurses Association maintained that, "The Quality Council needs to be made up of the public, health professionals and policy makers. The health economists and researchers should be resources to the Council – they should not be the drivers. We would see the composition of the Council as being approximately 50 per cent public representation."

And the Canadian Union of Public Employees said they "would like to see the Quality Council have representation from groups with a broad range of experiences, such as anti-poverty groups, women's groups, unions, community development activists, etc. If we recognize that social and economic factors influence health status, then we need expertise from people in these fields, not just from academics and bureaucrats."

Opinion was also varied with respect to the appropriate powers of a Quality Council. The College of Physicians and Surgeons stated, "We do not support the Quality Council having enforcement powers – it would simply provide advice and it would be the responsibility of the government to accept or reject that advice. In a democracy, you cannot take away the decision-making power from the elected people." Similarly, the Health Services Utilization and Research Commission said they "strongly agree with Fyke that a Quality Council should have the power to recommend, but no authority or power to implement."

Other witnesses, however, had a different view of the Quality Council's role. The Saskatchewan Government Employees Union told the Committee, "We are supportive of a Quality Council. We do not, however, want yet another layer of bureaucracy with no authority to implement recommendations, leaving the greater decisions to be determined by the politics of the day. The Council must have the authority to implement its decisions."

The Saskatchewan Medical Association told the Committee that, "The SMA is concerned that the scope, authority and accountability of the Quality Council is unclear and may simply add to the bureaucracy and cost of health care. The Fyke Commission has suggested that this Council requires a budget of up to one per cent of the health budget. This money may be better spent elsewhere."

And the Saskatchewan Association of Health Organizations asked the question, "Will the Quality Council have the ability to make anything happen, and if they can, how will they be accountable to the public?" And the Saskatchewan Medical Association concluded, "A Quality Council, if created, needs to be completely independent. It also has to have sufficient and appropriate accountability to achieve its mandates. A model similar to the Provincial Auditor may be most appropriate."

Responses to Chapter Five: In Support of Change

To support the proposed changes to the health system in Saskatchewan, the Commission on Medicare recommended:

- **9 to 11 health districts and clarification of their relationship to the Government of Saskatchewan;**
- **A structured dialogue on the delivery of health services to Aboriginal people;**
- **Coordinated human resources planning and management on a provincial basis;**
- **The renewal of health science education programs, including increased funding for health research, equalling 1% of public spending; and**
- **Investments in the information systems including the development of an Electronic Health Record.**

Health Districts

Over the course of the public hearings, and in the written submissions received by the Committee, no consensus emerged with respect to the Commission's recommendation for health district consolidation. Reaction to Fyke's proposals ranged from extremely supportive, to extremely critical, to somewhere in between.

The Committee heard that support exists for health district consolidation. For example, the College of Physicians and Surgeons maintained that, "Most of the smaller health districts lack sufficient critical mass to organize and sustain a reasonable range of high quality health services for their populations…We do think there is good reason to have some consolidation of health districts, although the precise number may require more study." The Town of Moosomin stated that they "see some merit and efficiencies resulting from larger districts," and the Saskatchewan Society of Occupational Therapists indicated they "support decreasing the number of health districts although we recognize that this change will not be immediately acceptable to all Saskatchewan citizens."

On the other hand, the Committee also heard very negative responses to Fyke's proposals. The Saskatchewan Association of Rural Municipalities, for example, said that Fyke's health district models were "totally unacceptable". The Town of Porcupine Plain echoed this view and suggested that, "The sense of community and local influence on decision making will be lost

with a move to larger districts. Amalgamation of health districts will not result in any significant cost savings. Many rural areas have just finished adjusting to the first round of health reforms. Please do not ask rural Saskatchewan to go through this all over again." And the Gabriel Springs Health District maintained that, "While some people accept that health district reconfiguration is inevitable, there is no support for the district models proposed by Fyke."

Several respondents suggested that any decisions about the number and size of health districts should await decisions on how and where health services will be provided in the province. According to the Saskatchewan Association of Health Organizations, "Any decision about the number or size of health districts should await decisions about what, and where, and how health services will be provided in the future". Or as the Twin Rivers Health District put it, "The appropriate number of health districts should not be determined until after we have had an opportunity to implement changes, evaluate service delivery after changes have taken place, and consult with stakeholders."

With respect to the health district boundaries, many witnesses expressed concern that Fyke's proposals do not take into account natural travel and service patterns. As the Saskatchewan Association of Rural Municipalities put it, "Fyke is just taking existing districts and joining them together. We need to look at trading and travel patterns, and the discussion must involve local communities and health districts."

Several health districts also pointed out that rather than being limited by existing health district boundaries, any reconfiguration should focus on strengthening the "strategic alliances" among communities who are currently working cooperatively to provide health care services, regardless of the particular district in which each community is located. For example, the Town of Craik told the Committee that, "Craik and Davidson are two different communities in two different health districts who have traditionally competed with one another at every level. These two communities are joining in recognizing one another's strengths and proposing to continue the collaborative efforts already begun in sharing physicians' services. We believe we can, at minimal cost to the Government of Saskatchewan, continue to provide outstanding primary care to a huge area of this province." And the Turtleford Health Advisory Committee observed that, "The Craik-Davidson presentation is remarkably comparable to that of Turtleford-Edam in the sense of being two nearby facilities in different districts working synergistically to provide health services to a large area."

The Pasquia Health District suggested that, "If the Province is really serious about boundary changes, restructuring must include social services and education. We are not suggesting boundary changes be forced upon social services and school divisions, rather, that common 'operating' boundaries must be established." The Prairie West Health District told the Committee that, "Amalgamation of health districts is not out of the question, however, the boundaries should be co-terminus with other government boundaries."

The Saskatchewan Government Employees Union expressed support for reducing the number of health districts but recommended that health districts be amalgamated according to the existing ten Service Areas. The Regina Health District also expressed support for reducing the number,

but only after "extensive dialogue and consultation with existing health districts, physicians, unions and publics."

Representatives of some rural communities pointed out that in their opinion, the most important issue was Fyke's proposed hospital, rather than health district, reconfiguration. "The consolidation of health districts isn't something that worries us too much," said the Town of Esterhazy. "The delivery of health care in centres such as Esterhazy is the critical issue – the size of the district in which the health care is delivered isn't of particular concern to us."

The Northern Health Stakeholders informed the Committee that that they strongly support Fyke's recommendation to maintain the three northern health districts.
Finally, Fyke's recommendation to clarify the relationship between health districts and the Government of Saskatchewan was met with universal agreement by all who spoke to the issue.

Health District Boards

If a lack of consensus emerged with respect to the appropriate number and size of health districts, even less consensus was evident in the testimony regarding the composition of health district boards. For example, the Committee heard from Dean Smith of Swift Current that health board members "should be appointed on the basis of their commitment and dedication to a better health care system. Elected boards have a tendency to be politically motivated and have special interest concerns rather than good health planning as their priority."

To the contrary, the Saskatchewan Government Employees Union told the Committee that, "all members of health boards should be elected", and the Saskatchewan Association of Health Organizations advised that they support "the current blended system of appointed and elected board members."

Opposing viewpoints were also heard regarding whether people who have a salaried or contractual relationship with a health district should be eligible to be appointed to or seek election to the board. On the one hand the Committee heard from witnesses such as private citizen Beverly DeJong who said, "I would like to give a big hurrah to the Fyke report for pointing out that it is inappropriate for physicians or anyone else who is on contract to, or directly employed by the district, to serve on its board. This is a clear conflict of interest..."

On the other hand, the Canadian Union of Public Employees summed up the contrary opinion when they said they were "opposed to any restrictions on health district employees running for board positions."

Delivery of Services to Aboriginal People

Very few witnesses spoke directly to the issue of health care service delivery for Aboriginal people, but those who did supported Fyke's call for a structured dialogue and agreed that Aboriginal health care must become a higher priority on the health care agenda. The Canadian Mental Health Association in Saskatchewan expressed the view that, "Addressing Aboriginal

and Northern health and social concerns, including mental health concerns, should move to the top of the government's priorities. Our success as a province depends on it."

The Saskatchewan Association of Health Organizations observed that, "Given the growing population of people of Aboriginal ancestry, the high health needs, and the need for an improved service delivery model to meet their needs, it is critical that we move health services for Aboriginal people to the top of the agenda. This must be a component of any province-wide plan for health services and must address services for people living on and off reserves in northern, southern and central Saskatchewan." The Saskatchewan Association of Health Organizations also stated that, "Partnerships between health districts and First Nations services are vital. Efforts at building these partnerships and developing contractual services should not be thwarted by intergovernmental contentions about jurisdictions."

The Saskatchewan Government Employees Union indicated that a need exists for "the provincial government, health districts and Aboriginal communities to develop a network to better determine the specific health care needs of Aboriginal communities and to ensure the delivery of health care services required by Aboriginal communities."

The Regina Health District stated that, "Health services for Aboriginal peoples are not meeting their needs today. A clear definition and clarification of policy and funding responsibilities of the federal government related to a new and revised network of health services for both on reserve and off reserve Aboriginal peoples must be developed. Once a national policy has been developed, provincial health care systems must accommodate Aboriginal health initiatives through more creative, client-centred programs and services. A national strategy must be designed to recognize the combined health and spiritual needs of Aboriginal peoples."

And finally, the File Hills Qu'Appelle Tribal Council told the Standing Committee that, "The First Nations world view and the First Nations philosophy is based on the holistic view of health that includes spiritual, mental, physical and emotional components...In order for a revamped health system to meet the needs of the First Nations people both on and off reserve, the system must be culturally sensitive to the physical, mental, emotional and spiritual needs of First Nations and work with First Nations to integrate traditional values into the contemporary health system."

Human Resources

Health care provider groups generally expressed support for the Commission's recommendation to coordinate human resources planning and management on a provincial basis. Witnesses tended to focus their comments regarding this recommendation on current staff shortages and the need to address issues of recruitment and retention.

The Saskatchewan Registered Nurses Association told the Committee, "We need health human resources planning that covers all health providers. We need to implement a comprehensive, coordinated, province-wide approach to health human resources planning that will examine all the human resources needed."

Similarly, the Saskatchewan Association of Health Organizations stated that, "A long term health human resource plan needs to be developed to clarify human resource needs and strategies, as well as to enable employers to plan for future service provision. This plan should be developed through a planning effort that involves government, the Saskatchewan Association of Health Organizations, professional bodies, colleges and universities, health employers, unions and communities."

Problems resulting from staff shortages and low staff morale, as well as the need to develop effective recruitment and retention strategies were identified by a wide range of groups. For example, the Saskatchewan Union of Nurses told the Committee that, "The province has set no goal for retention and recruitment and there is no one in the province who is monitoring and evaluating the effectiveness of retention and recruitment efforts...New graduates and experienced nurses are leaving the province because they have given up hope that chronic patterns of excessive overtime, increasingly unmanageable workloads and declining quality of patient care will be resolved."

Others who spoke to issues of recruitment, retention and staff morale included: The Saskatchewan Society of Medical Laboratory Technologists, the Saskatchewan Pharmaceutical Association, the Saskatchewan Association of Licensed Practical Nurses, the Dieticians of Canada (Saskatchewan Region), the College of Physicians and Surgeons, the Saskatchewan Registered Nurses Association, the Canadian Mental Health Association in Saskatchewan, the Community Health Co-operative Federation, the Saskatchewan Psychological Association, the Representative Board of Saskatchewan Pharmacists, the Saskatchewan Association of Health Organizations, the Canadian Diabetes Association (Saskatchewan Division), the Saskatchewan Society of Occupational Therapists, the Saskatchewan Government Employees Union, the Canadian Union of Public Employees, Saskatchewan Physiotherapy Association and the Saskatchewan Medical Association.

Research Funding

The University of Saskatchewan, health care provider groups and others who addressed the issue of research approved of Fyke's recommendation to increase funding for health research. The University of Saskatchewan told the Standing Committee that they, "warmly endorse the recommendation of Fyke for the creation of an Academic Health Science Centre in Saskatoon" and stated that, "Fyke's call for the province to commit from one to two per cent of its health budget to research would be a catalyst from which enormous benefits would flow."

The Health Services Utilization and Research Commission said they "strongly support the Fyke recommendation that at least one per cent of the health budget should be devoted to health research. This investment will enable Saskatchewan to develop an Academic Health Science Centre, continue to offer specialized health services, take advantage of federal funding for economic development and offer advanced educational opportunities for Saskatchewan students."

The Saskatchewan Registered Nurses Association recommended that the Health Sciences Faculty at the University of Saskatchewan become a Centre of Excellence for primary health

care education and research with a focus on rural and Aboriginal health. The Saskatchewan Association of Health Organizations echoed this view and stated, "Health science education programs should be renewed and should seek to establish Centres of Excellence in areas that are particularly relevant to Saskatchewan, for example, primary health care, rural health services and services to the Aboriginal population." The Saskatchewan Association of Health Organizations also maintained that, "Funding allocated to research initiatives should be maximized through funding partnerships with private industry."

Several groups recommended that part of the proposed research funding be targeted to particular areas, for example, the Dieticians of Canada (Saskatchewan Region) suggested increased dollars be devoted to nutrition research, the Saskatchewan Population Health and Evaluation Research Unit suggested that the research focus on the broader determinants of health and the Canadian Union of Public Employees maintained that, "a portion of these funds should be allocated to qualitative rather than quantitative research."

The Saskatchewan Society of Occupational Therapists expressed the view that Fyke's proposed health care research budget will "not only assist in further development of evidence-based practices, but may also serve as an enticement for recruitment and retention of health care professionals." The Chiropractors Association of Saskatchewan told the Committee that they also support an evidence-based emphasis on research funding, and that they are, "particularly supportive of the recommendation to increase funding to health care research by objectively linking it to health expenditure. We believe that research is essential for the viability of a health system in the same manner that research and development is for private industry."

The Regina Health District offered the view that a health research funding level of 0.5 per cent (rather than 1 per cent) of public health spending may be a more appropriate starting point.

Investments in Information

The Committee heard strong support expressed for the report's recommendations regarding investments in information systems including the development of an electronic health record.

The College of Physicians and Surgeons told the Committee, "We believe more investment in information management is an important priority and we would support Fyke's recommendations in this regard. Fyke describes the situation as one in which the health system is data rich but information poor. Those of us who work in the system find it very frustrating that data is often collected for very isolated functions, but data are not sufficiently connected to actually make judgments about whether the system as a whole is working as effectively and efficiently as it should."

The Saskatchewan Health Information Network expressed support for the recommendation and stated that, "SHIN can play a significant role in addressing many of the recommendations contained in the Commission on Medicare report."

The Saskatchewan Pharmaceutical Association said they "strongly support the recommendations from the report including the development of an electronic health record under SHIN." The

Representative Board of Saskatchewan Pharmacists also endorsed the recommendations, but "with the condition that pharmacists be permitted to access the important clinical information they require to effectively fulfill their role on the health care team."

The Saskatchewan Society of Medical Laboratory Technologists stated that, "A provincial electronic health record is essential in providing quality care to Saskatchewan residents. If this can bring an end to the vast amounts of unnecessary duplicate testing now being performed and lead to the sharing of results, there will be great benefits not only to the patients' care, but also to the bottom line of the health care budget."

The Canadian Union of Public Employees indicated they "support the development of an electronic health record that provides up to date, comprehensive information to health providers" but added that, "The government must place a strict ban on this information being sold or provided to companies for commercial interest."

The Saskatchewan Society of Occupational Therapists maintained that, "It is important that that the electronic health record be standardized across the province to avoid having individual health districts re-inventing the wheel."

Responses to Chapter Six:
Paying the Bills

To ensure the sustainability of a publicly funded health system, the Commission on Medicare recommended that future investments be directed to:

- **Changing the organization and delivery of primary and specialized services;**
- **Enhancing the overall health of the population;**
- **Research to support health services education and to develop and report on performance measures, service quality and value for money; and**
- **Managing change and creating a quality-oriented health services culture.**

Paying the Bills

On the issue of "paying the bills", the Committee heard repeatedly that the 40 per cent share of the provincial budget currently being allocated to health care should be sufficient, and, that our health care system should continue to be administered and funded publicly through general taxation.

Having said that, however, it should be noted that some witnesses who appeared before the Committee, as well as some individuals who submitted written testimony, indicated that they would be prepared to accept some form of user fee rather than lose their local health care services or facilities. The Town of Porcupine Plain told the Committee that, "Alternatives to the conversion or closure of rural hospitals, such as user fees, are worth considering." and according to the Town of Canora, "User fees and private sector health services would result in decreased waiting lists, better health and a much more efficient system." Spokespeople for the Medical Radiology Technologists suggested that, "User fees are a possibility. People in Saskatchewan have started to believe that health care is free." And the Saskatchewan Association of Rural Municipalities offered the view that, "We need to look at how we are funding health care in Saskatchewan. Some would suggest that we already have a two tier health care system because people who have the resources are leaving the province and country to access health care. People say they want no-cost services, but when you have no-cost services you have abuse, and we believe there is abuse in the system."

Conversely, many groups and individuals expressed extreme opposition to user fees. Their feelings were reflected in the following observation of Jack Boan of Regina who appeared before the Committee as a private citizen: "User fees have been called the 'zombie' of the health care system – something that is dead and buried but that keeps coming back to life. User fees have been shown to be unacceptable by logic and through practice." Another private citizen appearing

before the Committee, Beverley DeJong, put it this way: "I absolutely do not support user fees. Unless the fees are large, the contribution to the system would not be significant, particularly after you take away the cost of administering the fees. Who would be hurt? The people who can least afford to pay, the very people for whom medicare is to provide the greatest protection."

Shifting the Burden

The Committee also heard from the College of Physicians and Surgeons that, "Whatever rethinking or restructuring might occur, we would plead that we remember that the fundamental basis of the system is to try to spread risk across the entire population and to help those people who might be disadvantaged by disease. And we would therefore caution against any changes which would shift the financial burden more to those people who can least afford to bear the costs."

The Saskatchewan Health Coalition (Moose Jaw) echoed this view and said, "Change is inevitable. But steps will need to be taken to ensure that it is change for the better. It must not compromise access and shift the burden to families and individuals. It must not come at the expense of rural women, the sick, the poor and the elderly. Ultimately, if we are truly serious about reducing health care costs, we must do more to address the issues of poverty and inequality, inadequate housing and unequal educational opportunities."

Quality Over Quantity

The Health Services Utilization and Research Commission expressed the view that, "An investment in quality is what will improve health care. The biggest improvements in health care will come from focusing on improving system quality – not from providing more services." Similarly, Dr. Barry McLennan, Dean of Research at the University of Saskatchewan, said, "Spending more dollars, even if Saskatchewan could afford to do so – and it cannot – does not mean better health. We need to emphasize quality and not quantity." The Chiropractors Association of Saskatchewan maintained that, "The system must be reconfigured on an evidence-based manner and subjected to a culture of quality and accountability. All health care providers must be willing to submit all health care interventions to an evidence-based analysis to determine whether they are worthy of retention." And as mentioned earlier in this report, the Regina Heath District maintained that a specific percentage of the provincial health budget should be granted to health district boards on the condition that this funding be devoted to health promotion and disease/injury prevention initiatives.

Is More Money Required?

As mentioned, the vast majority of respondents were of the opinion that the amount currently being spent on health care is sufficient. Exceptions to this view included the New Green Alliance who maintained that, "The central assumption of the Fyke Commission is that we have a financial crisis in the health care system and we don't agree with that. In fact, spending on health care in Saskatchewan as a percentage of Gross Domestic Product (GDP) shows that spending on health care has steadily decreased since 1990 – from 6.4 per cent to 5.4 per cent of GDP. And so there has been a conscious decision by the government to reduce spending on health care…there

are adequate taxes there. What is lacking is the government's willingness to collect them...you cannot have a dramatic reduction of taxes and royalties on resources and maintain the health care system as it is today."

In their brief, the Saskatchewan Association of Health Organizations stated that, "The health system's budgetary problem is not mainly on the expenditure side of the equation, but on the revenue side. And the revenue solutions rest with the political choices of the provincial government."

The Saskatchewan Government Employees Union indicated that in order to secure the resources needed to expand services in a publicly-funded health care system, they "are looking to this Commission and to the provincial government to secure the necessary block funding from Ottawa to ensure the residents of Saskatchewan receive the funding they're entitled to."

Expansion of Coverage

Several groups suggested that health care funding be expanded to provide coverage for additional services and/or medications and supplies. These included the Chiropractors Association of Saskatchewan, the Canadian Diabetes Association, the Saskatoon Health Oasis, the Healing Co-operative of Saskatoon, the Midwives Association of Saskatchewan, the Representative Board of Saskatchewan Pharmacists and the Canadian Union of Public Employees.

Remuneration of Physicians

Differing views were presented to the Committee with respect to how physicians in Saskatchewan should be remunerated. The Saskatchewan Medical Association told the Committee that, "The SMA was never asked to comment on the issue of payment for physician services and was surprised to discover the specific recommendations for contracting both general practitioner and specialist services in the final report. The Association is concerned with the total lack of consultation on this issue when the Fyke Commission was gathering input...When it comes to the issue of contracting physicians, it is critically important that physicians be given choice in their method of payment. Experience in this province and elsewhere has shown that a 'one size fits all' approach to physician compensation is not optimal. We support the use of incentives to attract physicians to enter into contractual arrangements with health districts. Alternatively, we oppose any attempt to impose contracts. Given the current shortage of medical manpower, it would be folly to impose contracts on physicians who were reluctant to participate."

Dr. Jaco Greyling of Redvers said, "Being a salaried physician would mean you would not be remunerated for really working hard. If this were to come about, I can see a big loss of physicians to neighbouring provinces."

Conversely, the Committee heard from the Regina Health District that, "The fee-for-service mode of payment to family physicians as well as specialists is outmoded. It has the wrong incentives in it and doesn't provide us with the ability to offer alternate types of care that may be

more time consuming and may in fact be unnecessary in others...The Regina Health District strongly supports some alternate form of payment plan for specialists and other physicians, whether it be through a blended system of salary and fee-for-service, salary, or a revised fee-for-service schedule."

Similarly, the Community Health Co-operative Federation maintained that, "Alternate payment schemes are needed for physicians. The integration of fee-for-services private practice physicians into primary health care structures under alternate payment schemes such as contractual or salaried relationships must be a priority." And the Saskatchewan Government Employees Union stated stated that, "The one item missing from the Fyke report is any real plan for addressing fee-for-service charges by physicians. It would seem that the expectation for health reform is based upon changes in communities, services and health care providers with the exception of physicians."

And finally, the Committee heard that changing patterns of practice will have implications for the remuneration of physicians. For example, Dr. Dennis Kendel, Registrar of the College of Physicians and Surgeons offered the view that: "Generally, younger physicians are inclined to simply practice medicine and be paid fairly for their work. They don't want to invest in buildings. They don't want to be managers of staff. They don't want to be entrepreneurs. They don't want all that hassle. They simply want to practice medicine."

"But there is a generation gap. We have a significant number of older physicians who were raised in a different social context and they have invested in what they consider to be a small business."

"So I guess you have to work out a way that you can accommodate the changing expectations of the new cohort of physicians, which may be more aligned with societal objectives, but deal fairly with the people who are at the end of their careers and who began their careers on a different premise."

Other Concerns

Several groups and individuals drew to the Committee's attention issues and areas they felt had been missed or insufficiently addressed in the Commission on Medicare report.

Several respondents told the Committee that they had difficulty formulating definitive responses to the report's recommendations. As the Assiniboine Valley Health District put it, "Most people expressed concern over the complexity of the report. It was easy to read but it discussed concepts that most people were not familiar with. The report was vague and short on detail which added to the confusion about what the 'new world of health care delivery' would look like." Similarly, the College of Physicians and Surgeons observed that, "Many of the Commission's recommendations are macro in nature and much work needs to be done to flesh out how the recommendations would work at a more micro or operational level." And according to the Canadian Union of Public Employees, "The Commission did not provide enough detail regarding how the report's recommendations would be implemented."

A lack of shared understanding also appeared to exist among health care providers and members of the public with respect to the definition of terms used by Fyke. For example, there was no shared understanding among respondents of the meaning of terms such as "acute care", "primary care", "community care centre", and "regional hospital", to name but a few. As a result, the terms used and concepts discussed in the report often meant different things to different people.

The Saskatchewan Medical Association maintained that, "There are three outstanding and significant issues that are inadequately addressed in the Commission on Medicare. To some extent, these issues are the very ones that prompted the establishment of the Commission in the first place: Workforce Morale, Erosion of Public Confidence in the Health Care System and Sustainability."

The Palliative Care Association observed that, "Although there is much in the Fyke report that is innovative, we are concerned that there is virtually no serious reference to Palliative Care and Palliative Care Services...when Fyke describes the continuum of care he neglects to include palliative or end-of-life care. With our aging population and increased number of individuals living with chronic illnesses, and in light of the fact that in Saskatchewan, as in all of Canada, the mortality rate for our people is 100 per cent, this must be addressed."

The Lloydminster Health District maintained that, "There were a couple of areas that were fundamentally missed [in the report]. Mental health was one, and continuing care was another. We see in a number of different circumstances mental health issues impacting a variety of segments of our system right now, and we really had hoped and expected that mental health would have been given more attention and more emphasis within a review of a health care system in Saskatchewan...We've heard a lot about the changing demographics of Saskatchewan's population, the aging population, the baby boomers moving through our system, and yet continuing care seems to have received very little review within the recommendations of the Commission on Medicare."

The Living Sky Health District and South West Health District were also among those who expressed the view that the Commission did not adequately address long-term care issues. The Living Sky Health District said, "We are concerned that Mr. Fyke did not appropriately address long-term care services within his report. We believe strongly in an individual's need to live within his own community even when he can no longer adequately meet his own needs. Many of the elderly residents in our communities have lved their entire lives in one place, and have worked long and hard and have made many significant sacrifices for their community. To ask them to leave at the end of their days is not acceptable to us or to them."

Clinical Herbalist Flo Lavallie told the Committee that, "Something is missing from the health system as its exists today – there is a need for much more collaboration between the biomedical system of health care and selected complementary systems and therapies...The field of complementary and alternative health care must be recognized as having a meaningful role to play in the health care system in Saskatchewan and should be considered in all processes concerned with health care and health care reform in Saskatchewan."

The Healing Co-operative of Saskatoon said that, "When the Government of Saskatchewan created the Fyke Commission, we welcomed the initiative and participated in its work via a brief. The final report's recommendations, with their stress on enhancing the overall health of the population, investing in wellness as key to an effective and sustainable health system and the vision of 'truly interdisciplinary Primary Health Service Networks' are all promising. We find ourselves, the complementary health care providers, perfectly positioned to help make their implementation a reality. Unfortunately, and somewhat to our dismay, we found complementary therapies absolutely invisible in this report...and without the complementary care sector we believe the goals in this report are unattainable."

The Catholic Health Association of Saskatchewan/Saskatchewan Catholic Health Corporation shared with the Committee their vision of quality health care which they said, "must manage a high standard of physical care, while at the same time devoting time and energy to meeting the spiritual needs of those we serve...Mr. Fyke did not deal with this dimension at all and frankly, it's a glaring oversight."

Shirley Roettger, who appeared before the Committee as a private citizen, was also of the view that Fyke erred by neglecting to include the dimension of spiritual care and a focus on a truly holistic approach to healing.

Private citizen Beverley DeJong said that while the Fyke report briefly mentioned the matter of transportation on page 19, the report "understates the reality of the situation...a lack of transportation can be a complete barrier to health care services, even if the service is two blocks away."

The Saskatchewan Association of Boards of Addictions Services stated that they "are deeply concerned about the significant understatement and lack of insight into the significant contribution alcohol and drug abuse, the disease of alcoholism and chemical dependency play in the devastation of our health care system...and other than a brief reference on page 18, what is

missing from the report is any further reference to the role Community Based Organizations can play in providing significant health care services."

Several groups, including the Saskatchewan Association of Boards of Addictions Services, the Canadian Mental Health Association in Saskatchewan and the Saskatchewan Palliative Care Association also felt that the report failed to recognize the important role volunteers do and could play in the delivery of health care services.

Private citizens Sharon LaPorte and Rev. Albert Lalonde, both of whom suffer from multiple chemical sensitivities were of the view that the Fyke report failed to address issues surrounding multiple chemical sensitivity, neurotoxicology and environmental disease.

The Arthritis Society (Saskatchewan Division) told the Committee that, "In the Commission's report references were made to chronic disease and examples of health issues were utilized. However, the role arthritis plays was not recognized...The Arthritis Society recognizes that there is a role for non-profit agencies and we would like to work together with the health care system to ensure that individuals with arthritis receive the quality of care they need and deserve."

In conclusion, the response to the Fyke Commission on Medicare can best be described as "mixed" - ranging from extremely positive to extremely negative depending upon the particular recommendation being discussed.

APPENDIX 1 – LIST OF GROUPS AND INDIVIDUALS APPEARING BEFORE THE COMMITTEE

JUNE 26, 2001

Town of Canora
Registered Psychiatric Nurses Association of Saskatchewan
Town of Porcupine Plain
Saskatchewan Urban Municipalities Association

JUNE 27, 2001

Donalda Garner & Lorna Glasser
Saskatchewan Pharmaceutical Association
University of Saskatchewan
Royal University Hospital
Saskatchewan Heart Centre

JULY 3, 2001

Town of Craik
Midwives Association of Saskatchewan
Gabriel Springs Health District

JULY 4, 2001

Sharon Laporte
Rev. Albert Lalonde

JULY 10, 2001

Jack Boan
New Green Alliance
Saskatchewan Association of Licensed Practical Nurses
Town of Moosomin
Saskatchewan Health Information Network
Arthritis Society – Saskatchewan Division
Town of Esterhazy
Thomas A. Sokalski
Dean Smith
Northern Health Strategy
College of Physicians and Surgeons

JULY 11, 2001

Flo Lavallie
Chiropractors Association of Saskatchewan
Healing Co-operative of Saskatoon Ltd.
Dr. Lawrence Wiser
Canadian Diabetes Association
In Motion Partnership
Town of Tisdale
Town of Balcarres and Rural Municipality of Abernethy No. 186
Saskatchewan Parks & Recreation Association Inc.

JULY 17, 2001

Saskatchewan Union of Nurses
Saskatchewan Registered Nurses Association
Catholic Health Association of Saskatchewan/Saskatchewan Catholic Health Corporation
Village of Lintlaw & Rural Municipality of Hazelwood
Town of Indian Head
Kipling District Health Foundation
Saskatchewan Government and General Employees' Union
Town of Kipling
Regina Health District
Rolling Hills Health District
Community Health Cooperative Federation of Saskatchewan
College of Medicine, University of Saskatchewan
Town of Wynyard
Shirley Roettger
Canadian Union of Public Employees – Health Care Council
Saskatchewan Individualized Funding Inc.

JULY 18, 2001

Nap Gardiner
Saskatchewan Society of Occupational Therapists
Health Services Utilization and Research Commission
Canadian Mental Health Association, Saskatchewan Division
Candace Grocholski & Chantel Wotherspoon
Redvers Chamber of Commerce
Redvers and District Community Health Foundation
Redvers Health Centre Task Force
Redvers Ambulance
Redvers Medical Staff
Redvers Activity Centre
Redvers Right to Life
City of Humboldt
Moose Mountain Health District

JULY 24, 2001

Saskatchewan Association of Rural Municipalities
Saskatchewan Voice of People with Disabilities
Twin Rivers Health District
Dr. William Silver
Town of Kelvington/Pipestone Assiniboine Advocacy
Shellbrook Hospital Advisory Committee
Saskatchewan Population Health & Evaluation Research Unit
Saskatchewan Palliative Care Association
City of Lloydminster
Town of Cut Knife & Rural Municipality of Cut Knife No. 439
Saskatchewan Medical Association
Town of Kerrobert
Prairie West District Health Board
Saskatchewan Health Coalition, Moose Jaw Branch
West Central Municipal Government Committee
Town of Kindersley

JULY 25, 2001

Saskatchewan Emergency Medical Services
North-East Health District
Saskatchewan Association of Health Organizations
South Country Health District
Canada's Research Based Pharmaceutical Companies
Assiniboine Valley Health District
Dieticians of Canada – Saskatchewan Region
Village of Kennedy
Saskatchewan Physiotherapy Association
Pasquia Health District
Midwest District Health Board
Central Plains District Health Board
Pipestone Health District
Living Sky District Health Board
Sheri Pasztor
Turtleford Health Board Advisory Committee
ProFit Athletic Club

JULY 26, 2001

City of Swift Current
Prairie Women's Health Centre of Excellence
Beverley DeJong
Saskatchewan Psychological Association
Saskatchewan Association of Boards of Addictions Services
File Hills Qu'Appelle Tribal Council
Representative Board of Saskatchewan Pharmacists
Community of Hudson Bay
Rural Municipality of Elfros No. 307
High Country Consultancy
Wolseley Health Committee
Bourassa & Associates Rehabilitation Centre

APPENDIX 2 – LIST OF DOCUMENTS RECEIVED BY THE COMMITTEE

I. LIST OF DOCUMENTS TABLED BY WITNESSES WHO APPEARED BEFORE THE COMMITTEE

HCC 001/24 Registered Psychiatric Nurses Association of Saskatchewan: Written submission entitled "response to Standing Committee on Health Care in respect to the Final Report of the Commission on Mediacare" dated June 26, 2001.

HCC 002/24 Town of Porcupine Plain: Written submission dated June 26, 2001.

HCC 003/24 Rural Municipality of Porcupine No. 395: Written submission dated June 26, 2001.

HCC 004/24 Porcupine Plain & District Health Advisory Board: Written submission dated June 26, 2001.

HCC 005/24 Seniors, Porcupine Plain: Written submission dated June 26, 2001.

HCC 006/24 Saskatchewan Urban Municipalities Association: Written submission dated June 26, 2001.

HCC 007/24 Medical Laboratory Technologists: Written submission entitled "Response to Fyke Report on behalf of Medical Laboratory Technologists".

HCC 008A/24 Medical Radiation Technologists, Regina Health District: Written submission dated June 27, 2001.

HCC 008B/24 Medical Radiation Technologists, Regina Health District: Written submission entitled "Canadian Association of Medical Radiation Technologists Professional Development".

HCC 09A/24 Saskatchewan Pharmaceutical Association: Written submission dated June 27, 2001.

HCC 09B/24 Saskatchewan Pharmaceutical Association: Written submission entitled "Annual Report".

HCC 010/24 University of Saskatchewan: Written submission dated June 27, 2001.

HCC 011A/24 Saskatchewan Heart Centre: Speaking notes.

HCC 011B/24 Saskatchewan Heart Centre: Written submission entitled " Saskatchewan Heart Centre: A Place for the Heart".

HCC 12/24 Town of Craik and the Rural Municipality of Craik #222: Written submission.

HCC 13/24 Midwives Association of Saskatchewan: Written submission entitled "Midwifery in Saskatchewan" June 2001.

HCC 14/24 Gabriel Springs Health District: Written submission dated July 3, 2001.

HCC 15/24 Sharon Laporte: Written submission dated July 4, 2001.

HCC 16/24 Albert Lalonde: Written submission dated July 4, 2001

HCC 17/24 Jack Boan: Written submission.

HCC 18A/24 New Green Alliance: Written submission entitled "An Alternative Approach to Health in Saskatchewan" dated July 10, 2001.

HCC 18B/24 New Green Alliance: Written submission entitled "The Report of the Commission on Medicare and Local, Democratic Control" dated July 10, 2001.

HCC 19/24 Saskatchewan Association of Licensed Practical Nurses: Written submission dated July 10, 2001.

HCC 20/24 Town of Moosomin: Written submission dated July 2001.

HCC 21/24 Saskatchewan Health Information Network: Written submission.

HCC 22/24 Arthritis Society-Saskatchewan Division: Written submission.

HCC 23/24 Town of Esterhazy: Written submission.

HCC 24/24 Thomas A. Sokalski: Letter addressed to the Hon. John Nilson, Minister of Health dated June 3, 2001.

HCC 25/24 Dean Smith: Written submission dated July 10, 2001.

HCC 26A/24 Northern Health Strategy: Written submission entitled "Health Snapshot Northern Saskatchewan" prepared by Dr. James Irvine, Medical Health Officer.

HCC 26B/24 Northern Health Strategy: Written submission entitled "A Northern Health Strategy".

HCC 27/24 College of Physicians and Surgeons of Saskatchewan: Written submission.

HCC 28/24 Flo Lavallie: Written submissions from Tamara's House and Saskatoon Health Oasis.

HCC 29A/24 Chiropractors Association of Saskatchewan: Written submission dated July 11, 2001.

HCC 29B/24 Chiropractors Association of Saskatchewan: Written submission entitled "Chiropractic Care in Saskatchewan: The Case for Greater Coverage under Medicare" dated March 2000.

HCC 30/24 Healing Co-operative of Saskatoon Ltd.: Written submission.

HCC 31/24 Dr. Lawrence Wiser: Written submission.

HCC 32/24 Canadian Diabetes Association, Saskatchewan Division: Written submission dated July 11, 2001.

HCC 33/24 "In Motion" Partnership: Written submission.

HCC 34/24 Town of Tisdale: Written submission.

HCC 35/24 The R.M. of Abernethy #186 and The Town of Balcarres: Written submission.

HCC 36/24 Saskatchewan Parks and Recreation Association Inc.: Written submission dated July 11, 2001.

HCC 37/24 Saskatchewan Union of Nurses: Written submission dated July 17, 2001.

HCC 38/24 Saskatchewan Registered Nurses Association: Written submission entitled "Vision to Action" dated July 2001.

HCC 39A/24 Saskatchewan Catholic Health Corporation: Written submission dated July 17, 2001.

HCC 39B/24 Catholic Health Association of Saskatchewan: Written submission.

HCC 40/24 Town of Indian Head: Written submission dated July 17, 2001.

HCC 41/24 Saskatchewan Government and General Employees' Union: Written submission dated July 17, 2001.

HCC 42/24 Town of Kipling: Written submission dated July 17, 2001.

HCC 43/24 Regina Health District: Written submission dated July 17, 2001.

HCC 44/24 Rolling Hills Health District: Written submission dated July 17, 2001.

HCC 45/24 Rolling Hills Health District: Written submission dated July 2001.

HCC 46A/24 Canadian Union of Public Employees: Written submission dated July 17, 2001.

HCC 46B/24 Canadian Union of Public Employees: Written submission entitled "A Vision for Health Care: Building a Responsive Health Care System" dated August 2000.

HCC 47/24 Saskatchewan Individualized Funding Inc.: Written submission dated July 2001.

HCC 48/24 Saskatchewan Society of Occupational Therapists: Written submission dated July 18, 2001.

HCC 49/24 Health Services Utilization and Research Commission: Written submission dated July 18, 2001.

HCC 50A/24 Canadian Mental Health Association, Saskatchewan Division: Written submission dated July 2001.

HCC 50B/24 Canadian Mental Health Association, Saskatchewan Division: Written submission entitled "Making Sure Connections Happen: A Progress Report on Saskatchewan's Mental Health System" dated May 2001.

HCC 50C/24 Canadian Mental Health Association, Saskatchewan Division: Written submission entitled "Saskatchewan's Commission on Medicare: An Analysis of Findings and Implications" dated June 2001.

HCC 51/24 Candace Grocholski and Chantel Wotherspoon: Written submission entitled "Attitudinal Shift: Communication and Effective Change".

HCC 52A/24 Redvers Chamber of Commerce: Written submission.

HCC 52B/24 Larry Ewart: Written submission.

HCC 52C/24 Redvers & District Community Health Foundation: Written submission dated July 2001.

HCC 52D/24 Redvers Health Centre Task Force: Written submission entitled "Task Force Report".

HCC 52E/24 Redvers Ambulance: Written submission.

HCC 52F/24 Dianne Blezy: Written submission.

HCC 52G/24 Dr. Jaco Greyling: Written submission.

HCC 52H/24 Redvers Activity Centre Inc.: Written submission.

HCC 52I/24 Redvers "Right to Life": Written submission entitled "Redvers Health Centre".

HCC 52J/24 Redvers "Right to Life": Written submission including letter from Heidi Magotiaux and Family and other letters submitted by local residents.

HCC 53/24 City of Humboldt: Written submission dated July 18, 2001.

HCC 54/24 Moose Mountain Health District: Written submission dated July 18, 2001.

HCC 55/24 Saskatchewan Association of Rural Municipalities: Written submission dated July 24, 2001.

HCC 56A/24 Saskatchewan Voice of People with Disabilities: Written submission.

HCC 56B/24 Saskatchewan Voice of People with Disabilities: Written submission entitled "Saskatchewan's Disability Action Plan" prepared by the Saskatchewan Council on Disability Issues dated June 2001.

HCC 56C/24 Saskatchewan Voice of People with Disabilities: Written submission entitled "In Unison 2000: Persons with Disabilities in Canada"

HCC 57A/24 Twin Rivers Health District: Written submission dated July 24, 2001.

HCC 57B/24 Paradise Hill and District Advisory Committee: Written submission dated July 24, 2001.

HCC 58/24 Dr. William Silver: Written submission.

HCC 59A/24 Pipestone Assiniboine Advocacy: Written submission.

HCC 59B/24 Town of Kelvington: Written submission

HCC 59C/24: Town of Rose Valley: Written submission dated July 24, 2001.

HCC 59D/24 Margaret Franks: Written submission

HCC 60/24 Shellbrook Hospital Advisory Committee: Written submission dated July 24, 2001.

HCC 61/24 Saskatchewan Palliative Care Association: Written submission dated July 24, 2001.

HCC 62A/24 Lloydminster District Health Board: Written submission dated July 24, 2001.

HCC 62B/24 City of Lloydminster: Written submission dated July 24, 2001.

HCC 63/24 Town of Cut Knife and the Rural Municipality of Cut Knife No. 439: Written submission dated July 24, 2001.

HCC 64/24 Saskatchewan Medical Association: Written submission dated July 24, 2001.

HCC 65/24 Town of Kerrobert: Written submission dated July 23, 2001.

HCC 66/24 Prairie West District Health Board: Written submission dated July 2001.

HCC 67A/24 Saskatchewan Health Coalition, Moose Jaw Branch: Written submission in the name of Don Mitchell.

HCC 67B/24 Saskatchewan Health Coalition, Moose Jaw Branch: Written submission in the name of Dale Holmberg dated July 24, 2001.

HCC 68/24 West Central Municipal Government Committee: Written submission dated July 24, 2001.

HCC 69/24 Town of Kindersley: Written submission dated July 24, 2001.

HCC 70A/24 Saskatchewan Emergency Medical Services: Written submission.

HCC 70B/24 Saskatchewan Emergency Medical Services: Written submission entitled "Response to the Saskatchewan E.M.S. Development Project" dated February 15, 2001.

HCC 71/24 North-East Health District: Written submission.

HCC 72/24 Saskatchewan Association of Health Organizations: Written submission dated July 25, 2001.

HCC 73/24 South Country Health District: Written submission.

HCC 74A/24 Canada's Research Based Pharmaceutical Companies: Written submission entitled "Health Management: The Key to Quality Health Care, A Submission to the Standing Committee on Health Care" dated July 25, 2001.

HCC 74B/24 Canada's Research-Based Pharmaceutical Companies: Written submission entitled "Health Management: The Key to Quality Health Care, A Presentation to the Standing Committee on Health Care" dated July 25, 2001.

HCC 75/24 Assiniboine Valley District Health District: Written submission dated July 25, 2001.

HCC 76/24 Dieticians of Canada – Saskatchewan, Manitoba, and North-Western Ontario Region: Written submission.

HCC 77/24 Village of Kennedy: Written submission dated July 25, 2001.

HCC 78/24 Saskatchewan Physiotherapy Association: Written submission dated July 25, 2001.

HCC 79/24 Pasquia Health District: Written submission dated July 2001.

HCC 80/24 Midwest District Health Board: Written submission dated July 25, 2001.

HCC 81/24 Central Plains District Health Board: Written submission dated July 25, 2001.

HCC 82/24 Pipestone Health District: Written submission dated July 25, 2001.

HCC 83/24 Living Sky District Health Board: Written submission dated July 25, 2001.

HCC 84/24 Sheri Pasztor: Written submission dated July 25, 2001.

HCC 85/24 Turtleford Health Board Advisory Committee: Written document dated July 25, 2001.

HCC 86/24 ProFit Athletic Club: Written document dated July 25, 2001.

HCC 87/24 City of Swift Current: Written submission.

HCC 88/24 Beverley DeJong: Written submission dated July 26, 2001.

HCC 89/24 Saskatchewan Psychological Association: Written submission dated July 26, 2001.

HCC 90/24 Saskatchewan Association of Boards of Addictions Services: Written submission.

HCC 91/24 File Hills Qu'Appelle Tribal Council: Written submission dated July 26, 2001.

HCC 92/24 Representative Board of Saskatchewan Pharmacists: Written submission dated July 26, 2001.

HCC 93/24 Community of Hudson Bay: Written submission.

HCC 94/24 The High Country Consultancy: Written submission dated July 26, 2001.

HCC 95/24 Wolseley Health Committee: Written submission.

HCC 96/24 Bourassa & Associates Rehabilitation Centre: Written submission dated July 26, 2001.

HCC 97A/24 Prairie Women's Health Centre of Excellence: Written submission dated July 27, 2001.

HCC 97B/24 Prairie Women's Health Centre of Excellence: Written submission entitled "Prairie Women's Health Centre of Excellence Projects".

HCC 97C/24 Prairie Women's Health Centre of Excellence: Written submission entitled "Missing Links: The Effects of Health Care Privatization on Women in Manitoba and Saskatchewan".

HCC 97D/24 Prairie Women's Health Centre of Excellence: Written submission entitled "Action Plan for Women's Health in Manitoba and Saskatchewan".

HCC 97E/24 Prairie Women's Health Centre of Excellence: Written submission entitled "Presentation to the Standing Committee on Health Care, July 26, 2001".

HCC 98/24 University of Saskatchewan College of Medicine: Written submission dated July 17, 2001.

HCC 99/24 Town of Canora: Written submission dated July 20, 2001.

HCC 100/24 Jack Boan: Supplementary written submission dated July 26, 2001.

HCC 101/24 Regina Health District: Supplementary written submission dated July 18, 2001.

HCC 102/24 Town of Porcupine Plain: Supplementary written submission dated July 23, 2001.

II. BACKGROUND DOCUMENTS REQUESTED BY THE COMMITTEE

Commision on Medicare – Final report "Caring For Medicare: Sustaining A Quality System" dated April 2001

Saskatchewan EMS Development Project - Project report (including attachments) dated November 8, 2000.

Department Of Health – Health District Census and Map of Saskatchewan Health Districts and Health Facilities as of June 11, 2001.

Health Services Utilization and Research Commission – Summary Report No. 13 entitled "Assessing the Impact of the 1993 Acute Care Funding Cuts to Rural Saskatchewan Hospitals" September 1999.

Saskatchewan Association of Health Organizations – Submission to the Commission on Medicare entitled "A Response to the Commission on Medicare's Caring For Medicare: The Challenges Ahead" dated December 2000.

Saskatchewan Party – Submission to the Commission on Medicare entitled "Official Opposition Brief to the Fyke Commission on Medicare" dated February 15, 2001.

Saskatchewan Medical Association – Submission to the Commission on Medicare entitled "Brief to the Commission on Medicare" dated February 2001.

Canadian Union of Public Employees Health Care Council – Submission to the Commission on Medicare entitled "A Vision for Health Care: Building A Responsive Health Care System" dated August 2000.

Saskatchewan Union of Nurses – Submission to the Commission on Medicare entitled "Submission to the Commission on Medicare" dated November 2000.

III. WRITTEN SUBMISSIONS WERE RECEIVED BY THE COMMITTEE FROM THE FOLLOWING:

Shirley Aasen
Elizabeth Adair
Irene Adams
Robert M. Aellen
Pat Alelunas
Harriet Ames
Winnifred Amos
Anne E. Anderson
A. P. Andrews
James Archibald
Gladys Armitage
Jean Armstrong
M. G. Aseltine
Back To The Farm Research Foundation
Janet Badiuk
A. Bailey
Mr. & Mrs. Raymond Bailey
Pat Bakanec
Kim & Darryl Balog
Denise Bank
Sam & Kathleen Bank
Rose Bartlett
Jane Bates
Battlefords Health District
Bear Hills Rural Development Corporation
Rosemarie Beauchesne and other residents of Kindersley
Walter & Audrey Becker
Marg Beckstead and other residents of Rosetown
Hilda Beden
Shirley M. Belanko
Mavis & Mike Belchamber
June Bell
Thomas & Joan Bell et al.
Flora Bender
Myrtle O. Bergh
Mary Beriault
Big Sky Farms Inc.
Leona Bjerland
David Black
Deon Black
Evelyn Black
Wesley Black
Florence Blakley
Ivan D. Blakley
Cheryl Blezy
Agnes Booth
Clara Borowski

Joan Boyko
Steve Boyko
E. J. Braden
S.R. Brandon
Patrick H. Branigan
Walter & Justine Braun
Mel & Sheila Brayford
Christa Breitkreuz
Esther Brezinski
Ruth Brickley
Rena Britton
Carol Brown
Florence Brownridge
Ida Brownridge
Mary Burnett
Mabel Butler
Teklia Bylyna
Cecil Campbell
W. F. Campbell
Bertha Campeau
Jean Campeau
Canadian Federation of University Women / Yorkton
Melanie Cancade and other residents of Kipling
Kay Cann
Lyla Carlsen
Elmer & Florence Carlson
Gary Carlson
Omer & Anne Carriere
Kim Cave
Nancy Charteris et al.
Giselle & Wilfrid Chicoine
Mary Chisholm
R. S. Clancy
Alvey Clark
L. Amy Clark
Verna & James Clark
Dorothy Clarke
Donna & Gerald Coates and other residents of the Hudson Bay Area
Lorraine Colby
The College of Family Physicians of Canada, Saskatchewan Chapter
Edward Conacher
Robert A. & Myrtle C. Conacher
Conservapak
Jocelyne Cook
Carole Cooney et al.
Shirley Corkish
Priscille Couture
C. Del Cox
Glen & Patsy Craig
Lisa Craigie
Irene Cross
L. Cross
William & Joyce Crossman

Florence Cummins
Earl & Wanda Cunningham and family
Canadian Union of Public Employees Local #3974
Cheryl Daisley
Janice K. Daku
Alan J. Dakue
Joyce E. Dakue
Helen Danko
Russell & Merle Dayman
Justine Delmaire
Susan & Richard Delmaire
Doug Demery and other residents of Kindersley
Dorothy Desautels
Theresa Devine
Verna Dies
Verna Ditter
Don & Donna Dobson
Sadie Doner
Jean & Laurence Douslin
Betty & Autumn Downey
Alma Doyle
Eleanor Drinkwalter
Marcel Dubois
Ann Duhaime
Marg Duke
Helen & Frank Earnslau
East Central Health District
Catherine Edwards
Rick & Betty Anne Eisler
Lucy Eleg
Elrose Health Foundation Advisory Group
Elinor Evenson
Rev. Chris Ewing
Ethel Fabick
Marilyn E. Fahlman
Arlene Fears
Stella Federiuk
First Nations Diabetes Coalition
Catherine D. Fisher
Evelyn Fisher
Garth & Clare Ewart Fisher
Richard & Dorothy Fletcher
Hilda Folbar
A. Joyce Forgie
Myrna Foster
Mai F. Francis
Brian, Wendy, Chad, Dustin, & Candace Fricoe
Jean & Vincent Fritshaw and other residents of Tisdale
Candi Fritshaw-Leonard
Tyler Gall and other residents of Kipling
Gloria & Douglas Garner
H. D. Garner
Paula Garnier
Paula Garnier
Andre & Marie George
Helen Gervais
Margaret Gervais
Elden A. Gibson
Janet Werner & Sharon Goodchild
Wendy Gough
Charlie Goulet, E.M.T.
Laurine Goy
Elden & Marion Gradin
Lynn Gradin
Dr. H. C. Green
Green Head Health District
Robert & Ruth Greer et al.
Therese Groat et al.
Dave & Joan Gruber
Joyce Haas
Irwin & Mary Hainsworth
Alison Halford
L. Jean Halliday
Rhoda Hamilton
Elizabeth Hammel
Michael Hankewich
Wilfred Hanson and other residents of Livelong
Pat Hayes et al.
Bernard Hayunga
Mary Hayunga
Joyce Heintz
Laurent & Joan Henrion
Lorraine Henrion
Catherine Higgins
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Caroline Hinz
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Joanne Hollingshead
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Shirley Honeker
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Eleanor Howse
IMC Esterhazy Canada
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Lyle E. & Phyllis M. Jackson
Catherine & Byron Jamieson
Rose-Anne Johner
Sylvia & Stan Johns
Keith Johnson
Doug Jonassen & family
Donaldine E. Jones
Robert B. Kachmarski
Kevin & R. Kearns
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Bill & Bonnie Kell
Doris Kellington

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Kelvington Medical Clinic & Davidson Drug Ltd.
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Betty Anne Kopko
John Kopko
Juanita Korytko
Martha Krietemeyer
Audriene Kriger
Anne Kuyek
Frank Lakinger
Daniel Lamarre
Mary Lamborn
Nancy Larsen-James
Beth Larson
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Eliza Lavalley
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Clifford & Joyce Logan
Yvette Long
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Bernice Lorent
Sandy Loundes
Gloria Luscombe
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Gladys MacIntyre
Doreen Mack
Genny MacNamee
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Alida Madsen
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Maidstone Hospital Auxiliary
Barry Malindine
Therese Malindine
Julia Marcinowski
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Warren, Jackie, Zach & Kasia McChesney
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Lila McDermaid
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Patricia McDonald
David McIver
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Manford & Elaine Moen et al.
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Bonnie Morrow
Hazel & Bill Morson
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Ellen Muir
June Muller
George Myers
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Art Newton
Nexen Canada Ltd.
Iris Nicholson and other residents of Maidstone
Bill & Bonnie Kell Nilson
Cecile Nissen
Gladys & Robert Nolan
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Lena Numedahl
Jason Van Oirschot
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Cheryl Penney
Deborah L. Pennie
Wendel Peterson
Margaret Petrinchuk
Verda Petry
Marvyn Pickering
Dennis & Jeanette Pike
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Shirley Preddell
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Annette Randall
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Residents of McNab Place, Rosetown
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Cynthia Reynolds
Olive M. Robertson
C. A. Robson
Anne Rolheiser
Rose Valley Lutheran Parish
Rosetown Medical Group
Rosetown Senior Citizens Program
Jeff, Rhonda, Joey & David Ross
Linda Ross
Joan Roszell
Dr. Melanie Roth
Ivan A. Roussel
Phyllis Rowan
J. T. Rowan
Teresa Runge
Rural Municipality of Biggar No. 347
Rural Municipality of Coalfields No. 4
Rural Municipality of Eagle Creek No. 376
Rural Municipality of Eldon No. 471 and Municipal Health Holdings
Rural Municipality of Fish Creek No. 402
Rural Municipality of Frontier No. 19
Rural Municipality of Hazel Dell No. 335
Rural Municipality of Lakeview No. 337
Rural Municipality of Marriott No. 317
Rural Municipality of Maryfield No. 91
Rural Municipality of Mervin No. 499
Rural Municipality of Monet No. 257
Rural Municipality of Preeceville No. 334
Rural Municipality of Shellbrook No. 493
Rural Municipality of Three Lakes No. 400
Rural Municipality of Tisdale No. 427
Mary E. Rustad
St. Joseph's Hospital / Foyer D'youville Board
Saskatchewan Association of Speech-Language Pathologists and Audiologists
Saskatchewan Cancer Agency
Saskatchewan College of Physical Therapists
Saskatchewan Government and General Employees' Union
Saskatchewan School Trustees Association
Saskatchewan Society of Medical Laboratory Technologists
Saskatoon Health District
Karen Savage
Verna Sawchuk et al.
Ernie Scheer
Howard Schiltz
Marla Schlenker
Petronilla Schlosser
Alan P. Schreiner
Joe Schreiner
Janette Schumacher
Marion N. Scott
Paula Sealey
Dorothy Selke
Service Employees International Union, Locals 333, 299 & 336
Shellbrook & Districts Health Services Project
Cliff & Lois Sherwin
Bernice Shumi
Mel Simon
Audrey & Peter Simpson
Catherine & Don Skinner & Suzanne & Brent Keen
Mary Slager
Joyce & Maynard Slater
Marguerite Sloan
David B. Smith
Helen Smith
Louise Smith
Arlene Sostorics
South Central Protective Services Association
Southwest Health District
Esther Sparks
Don Spencer
Robert & Harry Sproull
Gordon Stange
Kathleen Stangland
L. Starkell
Bob Steil
Winnifred Stevenson
Greg Stewart
Terry & Eulilla Stretten
Gladys Sullivan

Phyllis Swaan
Kathleen Swalm
Frances Swan
Wanda Szakacs
Brian Szakacs
Izydor Szydlowski
Dora Tate
Cathy Taylor
Greg Taylor
Lyn Taylor
Lucienne Thomas
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Glenda Toms
Mr. & Mrs. Victor Toms
Marjorie Toppings
Richard & Nancy Toppings
Carol Torrance
Gerry & Joyce Toth
Denis & Linda Tourigny
Town of Coronach and the Rural Municipality of Hart Butte No. 11
Town of Kelvington
Town of Leader, Villages of Burstall, Prelate, Sceptre, Rural Municipalities of Clinworth, Deerforks, Happyland
Town of Midale
Town of Nipawin
Town of Preeceville
Town of Rocanville
Town of Rosetown
Town of St. Walburg
Town of Shaunavon
Town of Turtleford
Town of Unity
Town of Wawota
Albert Trish
Twin Rivers Health District
Gerardina Vercammen
Harry Vercammen
Harry & Dini Vercammen
Village of Windhorst
Mabel P. Wagstaff
Art Walde
Dorothy Walker
Barry Warsylewicz
Wawota Palliative Care Committee
Tom Wayling
Fred & Sandra Weekley
Stacey Weisbeck
Connie & William Wells
Don & Vi Wells
Dave Werner and other residents of Indian Head
Jean White
Rena Whiting
Donna M. Wickett
Gloria M. Wickett
Abe Wiens et al.
Norman Williams
Noreen Williamson
Perry L. Willoughly
Doug & Kay Wilson
Tannis M. Wilson and other staff of the Arcola Health Centre
John & Geraldine Wilton
Eleen Winters
Helen Wiszniak
Dr. R. H. Wood
Clara Faye Woodsworth
Lillian Woodward
Patricia Wyatt and other residents of Kisbey
Michael & Linda Yates
Werner Zacharias
Karen J. Zarn
Alice Zimmerman

IIII. Documents were also received from the following after the Committee had completed its Public Hearings

Valerie Andrie
Dorothy Barsi
Elda Beisenthal
Frank & Yvonne Bertalon
Joanne Bosch
Mrs. Edgar Curry
Eunice M. English
Glidden Hutterian Brethren
Paul Hofer et al.
Kahkewistahaw First Nation #72
Joe F. Kleinsasser et al.
Jackie Lemire & family
Katherine Muscoby
Moose Jaw-Thunder Creek District Health Board
Rev. David E. Mandie
Rose Pander
Cathleen Rydzik
Ada C. Sexsmith
South Central Health District
Shauna Toth